INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRY ACT INTO THE SUDDEN DEATH OF ADAM GREENSHIELDS ROBERT

Sheriffdom of South Strathclyde, Dumfries and Galloway at Hamilton

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

(Hereinafter referred to as "The Act")

Determination

by

William Erle Gibson Esquire

Sheriff of South Strathclyde,

Dumfries and Galloway at Hamilton

in the

Fatal Accident Inquiry

regarding the death of

ADAM GREENSHIELDS ROBERT

Hamilton: April 2006

The Sheriff determines

(1) In terms of section 6(1)(a) of the Act, that Adam Greenshields Robert, born 7th October 1942, who resided at 11 Firtree Road, Newmains, Wishaw died at approximately 23:30 hours on 29th April 2003 at 11 Firtree Road, Newmains, Wishaw.

(2) In terms of Section 6(1)(b) of the Act that the causes of death were:-

1.a Small Intestine Ischaemia and Obstruction;

due to

1.b Adhesions

2. Ischaemic Heart Disease.

(3) In terms of Section 6(1)(c) of the Act that there were no reasonable precautions whereby the death might have been avoided.

(4) In terms of Section 6(1)(d) of the Act there were no defects in any system of working which contributed to the death.

(5) In terms of Section 6(1)(e) of the Act the facts relevant to the circumstances of death are set out in the Note appended to this Determination.

NOTE

The Inquiry into the circumstances of the death of Adam Greenshields Robert commenced on 24th February 2004 and continued on 25th and 26th February, 19th and 22nd April and 4th June 2004, all before Sheriff Neilson. Evidence was led from eight witnesses, namely, Mrs Agnes Robert, the widow of Mr Adam Robert; Mr Alan Robert, his son; Dr Marjorie Black, the Consultant Forensic Pathologist who prepared the post-mortem report dated 5th June 2003 (Crown Production 4); Dr Colin Clark, a General Practitioner at Wishaw Health Centre who was on-call and dealt with the request by Mrs Robert for a home visit to her husband on the morning of 28th April 2003; Dr Azhar Ali, a General Practitioner with a Strathaven medical practice who was working as a locum for Primecare when he visited Mr Robert at his home in the evening of 29th April 2003; Dr David Walker, a Police Casualty Surgeon who attended at Mr Robert's home and pronounced him dead at 01:15 am on 30th April 2003; Dr David Willox, a General Practitioner with knowledge of the skills required of ordinary, competent General Practitioners, who prepared a report dated 23rd September 2003 (Crown Production 7); and Mr Andrew de Beaux, a Consultant General and Upper Gastro Intestinal Surgeon, who prepared a report dated 15th October 2003 (Crown Production 8).

Before he could hear submissions, Sheriff Neilson resigned. On 28th April 2005 the Sheriff Principal, having heard the solicitors for the parties, Ordered that another Sheriff be appointed to conduct the adjourned Inquiry and Directed the Sheriff to fix a preliminary hearing to Determine:

a. the issues, if any, which require to be addressed in oral evidence

b. the witnesses, who require to be recalled for that purpose

c. the extent to which the evidence already heard can be agreed and thereafter, to proceed as accords.

I was appointed and on 9th September held a preliminary hearing at which I heard the solicitors for the parties. It was agreed that it would probably be unnecessary to rehear the evidence of Mr Alan Robert, Dr Black, Dr Ali, Dr Walker, Dr Willox and Mr de Beaux. However, because what was said in the telephone conversation between Dr Clark and Mrs Robert on the morning of 28th April could have a significant impact on the Inquiry and because their recollections of that conversation spoken to in evidence were conflicting, it was suggested that it might be appropriate to hear their evidence anew so that when deciding whose evidence to prefer I would have the opportunity as they each gave evidence to assess their credibility and reliability. I adjourned the Inquiry to allow me to read the transcripts of the whole evidence and to decide how best to proceed.

A further diet was fixed for 13th January 2006 (the delay arising because I was absent for some weeks on sick leave). Before that diet I issued the following Note:

"It was clear from the discussions at the first meeting I had with agents that the first procedural decision to be made is whether or not I should hear afresh any evidence to assist me in taking a view on the credibility and reliability of witnesses, particularly the evidence of Mrs Robert and Doctor Clark who disagreed on the detail of what Mrs Robert told Doctor Clark during their telephone conversation on the morning of 28th April.

I hesitate, as I may appear to be prejudging the matter, to express a view on that but it seems to me helpful that I do so as it will allow parties to decide what should happen on 13th January 2006. If any party does not accept my view, and I will have no difficulty at all with that, we will hear further evidence and I would hope that arrangements could be made to hear it on 13th January after which, once the transcript of that further evidence has been obtained and considered, a hearing for submissions could be fixed.

Both witnesses appear to me to have given their evidence in a straightforward manner. However, Doctor Clark was relying on his contemporaneous notes whereas Mrs Robert was relying on her recollection supported by the letter she wrote some two weeks later, no doubt after anxious reflections and discussions with family members. For that reason I am inclined to prefer the evidence of Doctor Clark on the detail of that conversation and more than that, I have noted the discrepancies between the evidence of Mrs Robert of what she recalled having said in telephone conversations with Prime Care and the evidence contained in transcriptions of her telephone conversations which seems entirely reliable. For these reasons I would prefer the evidence of Doctor Clark to that of Mrs Robert on the detail of what she told him during that telephone conversation. For the avoidance of doubt, I am not suggesting that Mrs Robert was attempting to mislead the court or was being untruthful but rather that in the foregoing circumstances on a balance of probability her evidence is unlikely to be as reliable as that of Doctor Clark.

The questions for parties are simply these. Is any evidence to be heard afresh and if so of which witnesses and when? If not, are parties agreed that I should hear final submissions on 13th January 2006."

The Procurator Fiscal Depute and the solicitors for the parties having considered my Note, each advised the Sheriff Clerk that they had decided not to call for any evidence to be heard afresh but to proceed to submissions which I heard on 13th January. Those present were Ms E Gallagher, the Procurator Fiscal Depute for the Crown, Mr Baillie representing Mrs Robert and her family, Mr Donald representing Dr Clark and Dr Ali and Ms Anwar representing Primecare.

The duties and powers of the Sheriff in respect of his determination are contained in Section 6 of the Act. This Section provides as follows:-

"(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the Sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction -

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes of such death and any accident resulting in the death;

(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and

(e) any other facts which are relevant to the circumstances of the death."

I will deal with each of these items and issues in turn. It will have been clear from the extensive evidence, however, that some can be dealt with much more briefly than others.

First, it is natural when different and often conflicting interests are represented at an Inquiry that those who represent these interests will seek to persuade the Court to make findings which might have a bearing on possible claims for damages arising out of some contributory factors. It is well settled, however, that it is not the purpose of a Fatal Accident Inquiry to determine any question of civil or criminal fault or liability. In *Black v Scott Lithgow Limited* SLT 612, Lord President Hope at page 615G-H said:-

"There is no power in this section [s.6(1)] to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident ..... It is plain that the function of the sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, in so far as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required."

Carmichael on "Sudden Deaths and Fatal Accident Inquiries": "Scots Law on Practice" 3rd Edition 2005 at page 174 states:-

"If the cause of an accident is known, then it may well be possible, even with what is now said to be "the wisdom of hindsight" to point to something which, if done, might have avoided or even prevented the death or the accident resulting in the death. Questions of reasonable foreseeability may not be easily dealt with in an Inquiry and will be better left to any action of reparation which may ensue. The precise wording of s.6(1)(c) must be kept in mind. What is required is not a finding as to a reasonable precaution whereby the death or accident resulting in the death "would" have been avoided, but whereby the death or accident resulting in the death "might" have been avoided." ..... "Certainty that the accident or the death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a "probability" but a real or lively possibility that the death might have been avoided by the reasonable precaution."

Second, in terms of Section 4(7) of the Act, the rules of evidence shall be as nearly as possible those applicable in an ordinary civil cause brought before the Sheriff. The standard of proof is the balance of probabilities and facts and circumstances can be established without the necessity of corroboration.

BACKGROUND

In 1983 Mr Robert, because he was suffering from colitis, underwent abdominal surgery which involved the removal of part of his large bowel creating the need for him to use a stoma sack. In 2003 at the time of his death he suffered from diabetes, angina, high blood pressure and ischaemic heart disease.

Late in the evening of Saturday 26th April 2003 and into the Sunday morning Mr Robert, who was at home, complained to his wife Mrs Agnes Robert of abdominal pain. On Sunday 27th April at 9.27 am Mrs Robert telephoned Primecare (Emergency Out of Hours Medical Care). Mr Robert spoke to a Nurse and told her of his abdominal pain and that he felt hot and cold. The Nurse advised him to increase his intake of painkillers and to phone back if his condition did not improve. Mr Robert took more painkillers and his pain eased.

On Monday 28th April at 8.08 am Mrs Robert phoned her GP's surgery, Wishaw Health Centre, and told a receptionist that her husband had been sick all night and was suffering from abdominal pain and that she had phoned the emergency Doctor the previous day because of his pain: she requested a house visit by a Doctor. About half an hour later Dr Clark phoned Mrs Robert. Having discussed Mr Robert's condition and symptoms with her he concluded that Mr Robert had gastroenteritis. He told Mrs Robert that he would write a prescription to stop the diarrhoea, to be collected from the Health Centre together with a bottle to take a stool sample from Mr Robert. That morning Mrs Robert uplifted the prescription but not a bottle.

Mr Robert continued to suffer abdominal pain and sickness throughout the Monday and Tuesday and at 9.37 pm on the Tuesday Mrs Robert again phoned Primecare resulting in Dr Ali attending at 10.18 pm. Having examined Mr Robert, Dr Ali diagnosed gastroenteritis and a lung infection. He gave Mr Robert an injection to alleviate his vomiting and left medication for the lung infection. At about 11.30 pm Mrs Robert attempted to give her husband the medication but he did not respond. She immediately dialled Primecare but the line was busy: she then phoned for an ambulance. When the ambulance personnel arrived they could do nothing for Mr Robert and at 1.15 am on Wednesday, 30th April Dr Walker, the Police Casualty Surgeon, pronounced Mr Robert to be dead.

Section 6(1)(a) Where and When the Death took place.

Adam Greenshields Robert died at approximately 11.30 pm on 29th April 2003 at his home 11 Firtree Road, Newmains, Wishaw. He was formerly pronounced dead at 1.15 am on 30th April by the Police Casualty Surgeon, Dr David Walker.

Section 6(1)(b) Cause or Causes of Death.

In relation to this there was little, if any, disagreement. Dr Marjory Black carried out a post mortem examination and issued her report dated 5th June 2003. She found that scar tissue from the abdominal surgery which Mr Robert underwent in 1983 had caused adhesions in the intestine resulting in part of the small intestine becoming twisted and, because of a loss of blood, dead or ischaemic. A piece of this dead intestine had been pushed into the stoma sack causing a blockage which in turn lead to a build up in the stomach because of back filling of feculent fluid. She concluded that the primary cause of death was small intestine ischaemia and obstruction due to adhesions which would account for the symptoms of abdominal pain, vomiting and diarrhoea from which Mr Robert suffered in the days before his death; and that a potential contributory cause was ischaemic heart disease. Mr de Beaux accepted that the cause of death was clear from the post mortem findings but the mechanism of the death of Mr Robert remained unclear. He said that the twisting, or strangulation as he called it, of the bowel causing a blockage was a well recognised cause of death but the usual consequence was perforation of the bowel allowing spillage of intestinal content into the peritoneal cavity causing peritonitis and septicaemia. There had been no perforation of Mr Robert's bowel, no free fluid in the abdomen and no signs of peritonitis. Mr de Beaux could only speculate that a number of events came together on the evening of 29th April causing Mr Robert's heart to stop. He was generally unwell, he had ischaemic heart disease for which he was taking medication, he had been diabetic for at least ten years, he was probably dehydrated because of his vomiting and diarrhoea and there was probably bacteria in his bloodstream which would have an adverse effect on his cardio vascular system. Mr de Beaux suspected that Mr Robert had had a small vomit which caused a vasovagal event and his heart stopped and, because of his poor health, was unable to restart on its own accord resulting in his death.

The main focus of submissions was on the decision by Dr Clark not to make a home visit on the morning of 28th April. The Depute Fiscal referred first to the opinion of Dr Willox. He had referred to the recent history of Mr Robert who had been suffering from abdominal pain, vomiting and diarrhoea for some 36 hours. Mr Robert was a vomiting diabetic and, as a result, would become dehydrated more quickly than someone who was not diabetic and be more susceptible to developing ketosis which would call for hospitalisation. Dr Willox accepted that, on the basis of Mr Robert's symptoms, a diagnosis of gastroenteritis could have been reasonable but Dr Clark should have made a home visit to have face to face contact with Mr Robert to consider if there might be other reasons for his vomiting. In his opinion, taking account of the patient's age, the anxiety of his wife and the inability to make a diagnosis over the telephone which was secure enough to justify not visiting, more than fifty per cent of General Practitioners would have made a home visit. Taking all these conditions and symptoms together there was an overwhelming requirement on him to have made a home visit to Mr Robert. The Depute Fiscal then referred to the opinion of Mr de Beaux. Given the symptoms of abdominal pain, vomiting and diarrhoea he thought that gastroenteritis was the most likely diagnosis and if the diarrhoea and vomiting were settling then in his opinion it was reasonable for Dr Clark not to make a home call but he qualified that by saying that, before the decision not to make a home call was taken, Dr Clark should have established the time span over which diarrhoea and vomiting had continued and whether there was any change in the colour of the vomit because without that information a diagnosis would be difficult to make. He said that Dr Clark would have been mislead by the

mention of diarrhoea as this suggested that Mr Robert's bowel was working and waste was emptying into the stoma sack which indicated that there was not a blockage. However, as Mr Robert was diabetic and on cardiac medication and had been vomiting, it would have been prudent to have admitted him to hospital or at least to have telephoned later in the day to enquiry about his condition. Had Mr Robert been admitted to hospital on 28th April the obstruction would have been diagnosed and the likelihood of Mr Robert having survived would have been 90 to 95 per cent. The Procurator Fiscal submitted further that on the evening of 29th April Mr Robert's death might still have been avoided if Dr Ali had admitted him to hospital. Both Dr Willox and Mr de Beaux had expressed the opinion that in all the circumstances of Mr Robert's state of health he should have been admitted to hospital and, had he been, he would have had a fifty per cent chance of survival.

Mr Baillie adopted the submissions by the Depute Fiscal. He referred to my difficulty in assessing the evidence having not heard the witnesses. He also mentioned the difficulty for Mrs Robert when speaking to Dr Clark on the telephone as he was not her usual General Practitioner. That being so a face to face meeting would have been more productive and enabled Dr Clark to obtain more vital information from a lady who was not particularly articulate. He argued that, bearing in mind the long period over which Mr Robert had had a difficulty with his bowel and was now complaining of a problem with his bowel, Dr Clark should have been alerted to the need for a visit which was all the more imperative as Mr Robert suffered from diabetes and a heart condition and had recently been put on medication because of bruising to his side sustained a month or two previously; he also had high blood pressure and was aged 60. It would have been prudent to get a patient who had been vomiting for several days, was diabetic and took cardiac medication into hospital. He submitted that in all these circumstances a home visit would have been reasonable. He then referred to the reason behind Dr Clark not considering that Mr Robert might have a blockage or obstruction; namely, that he was suffering from diarrhoea. Mr Baillie argued that it was not good enough for Dr Clark to rely on the word of Mrs Robert, an inarticulate lady, that her husband was suffering diarrhoea. Mr de Beaux had said that it required more than one episode to diagnose diarrhoea. It was not a symptom which Mrs Robert was in a position to diagnose and she should not have been relied on. He referred to the evidence of Mr de Beaux that it was very difficult to diagnose diarrhoea in someone with a stoma sack and so, when Mrs Robert said that her husband had diarrhoea, he should have asked many more questions to satisfy himself of that. All that Mrs Robert saw on Sunday night was dark liquid stuff coming out of her husband's stoma bag when he emptied it which she mistakenly called, diarrhoea. Dr Clark should not have relied on that and ought to have paid a visit. Had he gone he would have seen that it was not diarrhoea. Dr Clark also relied on her information that her husband was vomiting. He should have asked more questions about that such as the pattern, the frequency and whether it had stopped. Dr Clark noted that the vomiting was settling but that did not necessarily mean that it had stopped and he ought to have considered how the vomiting was affecting the medication which Mr Robert was taking for of his diabetes and heart condition. According to the Primecare notes, on the Sunday Mr Robert was not suffering from vomiting or diarrhoea and so the vomiting was recent. Dr Clark had accepted that if Mr Robert continued to vomit for a period of time then that would potentially be dangerous. Because Mr Robert was diabetic it would have been sensible to know what his blood sugar reading was and what was in his stoma bag. If

his blood sugar was low that could have made him unwell. He then submitted that Dr Clark did not have a sufficient history of Mr Robert which was important when making a diagnosis of a patient. He noted that Dr Clark had not ascertained if Mr Robert was passing urine which was important to know. With a house visit he could have found out. Dr Clark had spoken to Mrs Robert for 2 minutes 40 seconds which was insufficient time to take a full history. If Dr Clark had attended he would have checked the stoma bag and found that it was blocked, he would have learned that Mr Robert was not going to the toilet and he might have had the opportunity to examine his vomit. And so had a visit been made, on the balance of probability Dr Clark would have arranged for a hospital admission.

Mr Donald replied to these submissions by the Depute Fiscal and Mr Baillie. He referred to the conflict in the evidence of Mrs Robert and Dr Clark of their respective recollections of their telephone conversation. He pointed out that Dr Clark himself had accepted that if Mrs Robert had told him that her husband had been sick and that his vomit was worryingly "black and stinking" then he should have made a home visit. However, Dr Clark's evidence was that he was told of a history of diarrhoea and vomiting over the preceding two days associated with abdominal pain; that the vomiting was settling and the colicky pains were also settling. These symptoms sounded like a gastroenteritis type of infection. There were signs that they were improving. He discussed the management with Mrs Robert and arranged for a prescription for loperamide capsules to be made available which would settle the diarrhoea symptoms and for a stool sample to be collected from the patient and handed in for bacteriological examination. He understood Mrs Robert to be happy with this advice and he told her that if there was any change in her husband's condition she should contact the practice again and a visit would be arranged. He insisted that Mrs Robert did not mention that the sickness and diarrhoea were black nor did she mention that they had a particularly strong or pungent smell. Mr Donald then gave his reasons for why I should prefer Dr Clark's recollection of the conversation. First, his contemporaneous record made at the time was available; second, he was a very experienced GP who, if told that the vomit was "black and stinking", would have noted that and would have made a visit; third, Mrs Robert had said that she advised Primecare on the Tuesday evening that her husband's vomit had been "black and stinking" but neither the transcript of the conversation then nor at any other time with Primecare disclosed that; fourth, in giving evidence Mrs Robert was adamant that she had told Dr Clark that her husband's vomit was "black and stinking" but this contradicted her own earlier evidence that by time she spoke to Dr Clark there had been only one episode of sickness that morning, that it was black but that there was no smell from it although she subsequently referred to there being a "wee smell" from it; fifth, Mrs Robert was adamant that Dr Clark had returned her call within 3 minutes but the telephone records showed that she made her call at 8.08 am and Dr Clark returned it at 8.40 am, an interval of 32 minutes. Mr Donald then, looking at their evidence broadly, considered the evidence of Dr Willox and Mr de Beaux on the basis of Dr Clark's recollection of his conversation with Mrs Robert. Dr Willox said that he would still have visited knowing that the patient was diabetic and had been vomiting along with diarrhoea, a visit being necessary to ascertain the patient's true condition. However, Dr Willox accepted that gastroenteritis was a reasonable diagnosis particularly as Mr Robert appeared to be improving. Dr Willox accepted that a significant minority, slightly less than fifty per cent, of GPs would have done as Dr Clark did, informing the patient that if he got worse or there was no

improvement then a home visit would be made. Dr Willox raised as factors for visiting, the patient's age, his condition, the anxiety of his wife and the inability of a doctor to make a diagnosis over the telephone, but he conceded that Dr Clark was not aware of any particular anxiety on the part of Mrs Robert. Mr Donald submitted that Section 6(1)(c) raised two questions, the first being whether a reasonable precaution had been taken and second, whether death might have been avoided. He argued that it could not be said that Dr Clark acted unreasonably in not visiting Mr Robert. Mr Donald referred to the report by and the evidence of Mr de Beaux. In his report, he observed that although the wrong diagnosis (with hindsight) had in fact been made on the information which Dr Clark obtained, he was entitled to make a diagnosis of gastroenteritis: and, when giving evidence, he confirmed this. Mr de Beaux accepted that Dr Clark had acted reasonably in his diagnosis and management of Mr Robert. Mr Donald submitted that taking account of the independent evidence of Dr Willox and Mr de Beaux and proceeding upon Dr Clark's recollection of his conversation with Mrs Robert it could not be said that Dr Clark acted unreasonably by not visiting: a decision to visit was a matter of clinical judgement to be made by a doctor at the time based on a whole range of factors. Dr Clark was a very experienced General Practitioner who had clearly demonstrated when giving evidence that he had given the matter considerable thought and care. He then submitted that when considering if a reasonable precaution had been taken, that was to be determined in the context of circumstances where the death might have been avoided, "might" meaning a real possibility, more than mere speculation. He submitted that there would have to be a causal connection between a visit which might have been made and Mr Robert's admission to hospital. Dr Willox, when asked what Dr Clark would have found when he visited said that he had insufficient information to say whether Dr Clark would have seen sufficient signs to make him aware that Mr Robert was sufficiently ill to be admitted that morning. It would have depended on how Mr Robert had appeared when he had been visited. Dr Clark might well have told Mr Robert to continue to take oral fluids and then visited him the next day to see how he was getting on. Mr Donald submitted that there was insufficient evidence to establish any causal connection between a visit to Mr Robert and a course of action which might have avoided his death. Accordingly, he submitted that no finding could be made in terms of Section 6(1)(c).

Mr Donald then considered whether Dr Ali, after having examined Mr Robert on the evening of Tuesday, 29th April, should have arranged for his admission to hospital. He noted that there was conflict in the recollections of Mrs Robert and Dr Ali of his visit. First, she insisted that she told Dr Ali that her husband's vomit had been "black and stinking" but this was inconsistent with Dr Ali's contemporaneous notes; second, she was insistent that Dr Ali had examined her husband's tongue and found it to be black but this also was inconsistent with his contemporaneous note and her son's evidence; third, she said that Dr Ali did not take any previous medical history, that he did not question what Mr Robert was drinking, that he did not ask what prescriptions were being taken by Mr Robert, that he did not take his temperature and that Mr Robert was not alert, all of which assertions were at odds with the contemporaneous record made by Dr Ali. Mr Donald submitted that Dr Ali's account and recollection should be preferred. Dr Willox in his report noted that at the time of Dr Ali's examination Mr Robert was only around one hour away from death and even if Dr Ali had taken the decision to admit him to hospital it could well have taken an hour or more for an ambulance to arrive to take him to hospital so that there was little

likelihood that he would have survived. Mr de Beaux accepted that had Dr Ali decided to admit Mr Robert to hospital it would probably not have made any difference. Dr Willox was concerned that Dr Ali apparently did not check for bowel sounds or on Mr Robert's diabetic condition and was surprised that Dr Ali, following his examination, did not realise how ill Mr Robert was but he was favourably impressed by the extensive notes taken by Dr Ali and, by inference, the thoroughness of his examination. Mr Donald accepted that the proximity of the examination by Dr Ali to Mr Robert's death caused a difficulty but submitted that this could be understood by taking account of the mechanism of death postulated by Mr de Beaux. Mr de Beaux was of the view that either Dr Ali had been quite mistaken as to his findings or he was presented with a rather complicated and unique set of circumstances which lead to Mr Robert's death shortly after the visit. Mr Donald argued that the latter appeared more likely in view of the thoroughness of Dr Ali's examination. He submitted that it could not be held that Dr Ali acted unreasonably and, as there was no clear evidence that this would have made any difference to the outcome, there could be no finding under Section 6(1)(c) arising from Dr Ali's involvement.

Mr Donald replied to the Fiscal's suggestion that it would perhaps be good practice for doctors to be proactive, in the management of a case involving a patient with a history of serious medical conditions who had requested a home visit which was initially refused, by telephoning the patient's home later in the day to enquire about the patient's condition. This had not been put to the experts and so there was no evidence to support it. In his view it was a matter for clinical judgement which could not be regulated. He submitted that there were no defects in the system relevant to the circumstances and cause of Mr Robert's death.

Mr Donald then replied to the submissions by Mr Baillie. He had submitted, first, that it was inappropriate to rely on information given over the telephone but it was clear from the evidence that GPs frequently did rely on such information and did not make house visits in the first instance, that being a matter for clinical judgement; second, that because of Mr Robert's history a visit had to be made but Dr Clark had had the history in front of him with his records on the computer screen and was aware that Mr Robert had suffered from a chronic condition for a long time; third, that because the symptom of diarrhoea was so important Dr Clark should not have relied on what Mrs Robert told him and had he visited Mr Robert he would have realised that he was not suffering from diarrhoea, but that was speculation and, in all the circumstances, Dr Clark was justified in relying on the information from Mrs Robert; fourth, that as his vomiting was an important symptom Dr Clark should have asked more questions about it, but he had and was told that it was settling and, crucially, Dr Clark's evidence was that he had told Mrs Robert to phone back if she felt that was necessary so that she was not left in a vacuum; fifth, that if Dr Clark had visited he would have seen that Mr Robert was suffering from dehydration and a blockage but Dr Ali who had visited found no signs of dehydration or of a blockage and the mechanism of death which Mr de Beaux thought was most likely was not consistent with an obstruction arising from strangulation of the bowel.

I heard brief submissions by Ms Anwar on behalf of Primecare. She explained that Primecare provided an out of hours duty Doctor Service for General Practitioners by providing a telephone answering service, by arranging for medical staff to prioritise

calls and thereafter by arranging transportation for duty doctors to and from patients' homes. Primecare did not employ duty doctors and was not responsible for their clinical judgements. She highlighted a number of instances of where the evidence of Mrs Robert was inconsistent with what she had said on the telephone to one or other of several members of Primecare staff, her conversations with the staff having been fully and accurately recorded and transcribed and lodged as a Production.

Having heard and considered the submissions I have carefully re-read all the evidence and it is clear to me that every issue of any significance was fully visited and covered during the thorough questioning of the witnesses.

I have considered the submissions which addressed the issue of the conflicting evidence of Mrs Robert and Dr Clark and of Mrs Robert and Dr Ali. I have not departed from my provisional position that I prefer the evidence of Dr Clark of what was discussed between them. Again, I wish to make clear that I am not suggesting that Mrs Robert either attempted to mislead the court or was being untruthful but rather that, on a balance of probability, I prefer as more reliable the evidence of Dr Clark.

Both Dr Willox and Mr de Beaux prepared reports which were productions. They prepared their reports on the basis of information contained in a number of documents provided to them by the Procurator Fiscal including the letter dated 13th May 2003 written by Mrs Robert to the Practice Manager of Dr Clark's practice. In that letter she wrote *inter alia* "Dr Clark telephoned me asking me again what the symptoms were. I explained Adam's sickness and diarrhoea was worryingly black and seemed to have a strong pungent smell." Their reports, understandably, were predicated in part on that letter and the references in it to the conversation with Dr Clark which were materially significant. As I have explained I have preferred the evidence of Dr Clark of what Mrs Robert said to him and so the conclusions in their respective reports, in so far as they were reached on the basis of those inaccurate references to that conversation, became invalid and it was only when they were cross-examined by Mr Donald, who put to them what Dr Clark recollected of the conversation, that they found themselves having to reconsider their conclusions. (That they were both questioned at considerable length on each of the two versions of that conversation goes some way to explaining why the Inquiry lasted for so many days).

Conclusion

I intend to deal with the submissions relating to Section 6(1)(c) fairly briefly.

When taking a view on decisions made by Dr Clark I have relied primarily on the evidence of Dr Willox and Dr Clark. Mr de Beaux recognised that he was not qualified to comment on decisions made by a General Practitioner he being, as he said, "a hospital doctor". Dr Willox has been a General Practitioner for some nineteen years and has been involved in teaching for about ten years. He helps to assess whether or not General Practices should be accredited as suitable to train GP Registrars and he himself is qualified and accredited as a trainer of GP Registrars. I was entirely satisfied that I should treat his evidence as having been given by an expert witness. Dr Clark has been a GP for twenty seven years and,

while not himself qualified as a trainer, is a partner in an accredited practice. There being only a few accredited training practices that speaks well of the quality of standards and systems of his practice. As I read the notes of the evidence of both Dr Willox and Dr Clark I was impressed by the clear and coherent way in which they gave their answers.

I have noted that both Dr Willox and Mr de Beaux agreed that on the information which Dr Clark had, namely, that Mr Robert was being less sick, his pain was settling and he had diarrhoea which indicated that his bowel was working, his diagnosis of gastroenteritis was the right one.

It was the opinion of Dr Willox that, by a fine margin, a majority of GPs would have made a home visit to Mr Robert and so, in my opinion, it follows that to have visited would have been a reasonable precaution. However, because of the qualification in that opinion, and because of the explanations given by Dr Clark for not visiting, I have accepted the submission that it could not be said that Dr Clark acted unreasonably in not visiting Mr Robert. Necessarily taking a broad view of the very extensive evidence I am of the view that Dr Clark acted reasonably in not making a home visit. His information was that Mr Robert's vomiting had stopped and that his diarrhoea, while it had not stopped, was settling. He was aware of the risk of dehydration being caused by diarrhoea and so he arranged for Mr Robert to take loperamide to stop the diarrhoea and told Mrs Robert that her husband must keep up his fluid intake. He had Mr Robert's medical history in front of him and was aware that he was diabetic. He considered it unnecessary to check his blood sugar level as he was taking fluids including sugar drinks, he had been unwell for less than 36 hours and his symptoms were improving. He was aware that Mr Robert had a stoma bag but, as Mr de Beaux confirmed, if there was to be trouble with the stoma bag it would usually occur regularly over the period for which it had been fitted and it was not something which was likely to cause a problem out of the blue twenty years late. I was satisfied that Dr Clark did not decline to visit because he was under pressure: his practice have a good system in place whereby the doctor responsible for house visits does not see patients attending the surgery by appointment.

It was Mr de Beaux's opinion, which was not challenged, that had Mr Robert been admitted to hospital on Monday, 28th April he would have had a 90 to 95 per cent chance of survival and had he been admitted in the late evening of Tuesday, 30th April he would have had a 50 per cent chance of survival.

I accepted Mr Donald's submission that Section 6(1)(c) raised two questions, the first being whether a reasonable precaution, in this case, a home visit, had been taken and second whether, if a reasonable precaution had been taken, death might have been avoided; and his further submission that there had to be a causal connection between those two questions, namely, if Dr Clark had made a home visit what he would have learned about Mr Robert's state of health would have satisfied him that he should arrange to have Mr Robert admitted to hospital.

I am satisfied, by the opinion of Mr de Beaux that had Mr Robert been admitted on Monday, 28th April he would have had a 90 to 95 per cent chance of survival, that not just might Mr Robert's death have been avoided but most probably it would have been.

Having accepted Mr Donald's submission that there would have to be a causal connection between a visit and Mr Robert's admission to hospital, I could only speculate on what symptoms Dr Clark might have found had he visited and whether those would and should have lead him to decide to have Mr Robert admitted. Dr Willox was unable to say if, had Dr Clark visited Mr Robert, he would have seen signs of how ill he was and that he would have hospitalised Mr Robert. And so I am satisfied on a balance of probabilities that that causal connection does not exist.

The Procurator Fiscal further submitted, properly as she represented the public interest, that a reasonable precaution was that Dr Ali should have arranged for Mr Robert to be admitted to hospital which would have given him a 50 per cent chance of survival. There was, however, no enthusiasm for that submission from any other party and, in particular, I was satisfied by the evidence of Dr Willox that it was unlikely that an ambulance would have arrived at the home of Mr Robert before his death and most unlikely that an ambulance, had it arrived, would have got him to hospital in time to receive the necessary attention to save his life.

Accordingly, I am unable to find that there was any reasonable precaution whereby the death of Mr Robert might have been avoided.

Section 6(1)(d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death.

With respect, there was no evidence to support the submission by the Procurator Fiscal that Dr Clark's invitation to Mrs Robert to phone again if she were concerned about her husband's condition, which she did not do, demonstrated a defect in the system which could be cured by introducing a practice requiring General Practitioners to be proactive and themselves phone the patient's home later in the day to enquiry about his condition.

Finally, may I extend to Mrs Robert and her family my sympathy on their loss of a husband and father and for the anxiety which this protracted Inquiry must have caused them.